

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS5460AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2010
NAME OF PROVIDER OR SUPPLIER GOLDEN SUNSHINE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 8333 JEREMIAH LODGE AVE LAS VEGAS, NV 89131		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	<p>Initial Comments</p> <p>Surveyor: 28384</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.</p> <p>This Statement of Deficiencies was generated as a result of a required grading re-survey conducted in your facility on 1/15/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division.</p> <p>The facility is licensed for 10 Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. The census at the time of the survey was five. Five resident files were reviewed and four employee files were reviewed.</p> <p>The facility received a survey grade of A.</p>	Y 000		
Y 108 SS=F	<p>449.200(3) Per File - Storage & Availability</p> <p>NAC 449. 200</p> <p>3. The administrator may keep the personnel files for the facility in a locked cabinet and may, except as otherwise provided in this subsection, restrict access to this cabinet by other employees of the facility. Copies of the documents which are evidence that an employee has been certified to perform first aid and cardiopulmonary resuscitation and that</p>	Y 108		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS5460AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/15/2010
NAME OF PROVIDER OR SUPPLIER GOLDEN SUNSHINE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 8333 JEREMIAH LODGE AVE LAS VEGAS, NV 89131		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 108	Continued From page 1 the employee has been tested for tuberculosis must be available for review at all times. The administrator shall make the personnel files available for inspection by the bureau within 72 hours after the bureau requests to review the files. This Regulation is not met as evidenced by: Surveyor: 28384 Based on record review and interview on 1/15/10, the facility failed to ensure caregiver tuberculosis records and proof of first aid and cardiopulmonary resuscitation training were available for review at all times (Employee #1 - file not available for review). Severity: 2 Scope: 3	Y 108			
Y 936 SS=F	449.2749(1)(e) Resident file-NRS 441A Tuberculosis NAC 449.2749 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto.	Y 936			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS5460AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/15/2010
NAME OF PROVIDER OR SUPPLIER GOLDEN SUNSHINE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 8333 JEREMIAH LODGE AVE LAS VEGAS, NV 89131		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 936	Continued From page 2 This Regulation is not met as evidenced by: Surveyor: 28384 Based on record review on 1/15/10, the facility failed to ensure 1 of 5 residents complied with NAC 441A.380 regarding tuberculosis testing (Resident #2) which affected all residents. Severity: 2 Scope: 3	Y 936			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.